

Keynote Speech by

***Dr Samlee Plianbangchang
Regional Director, WHO South-East Asia***

at the

***36th Annual Meeting of Voluntary Health
Association of India***

***10 November 2010,
New Delhi, India***

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Regional Director, WHO South-East Asia,***

Distinguished participants, ladies and gentlemen,

It is a privilege and an honour for me to have the opportunity to deliver the keynote speech at this august gathering. I overwhelmingly thank the organizers of the meeting, in particular Dr Alok Mukhopadhyay, Chief Executive of the Voluntary Health Association of India, for the invitation.

Ladies and gentlemen,

The principle of primary health care (PHC) has served as an important tool for VHAI on its journey to its vision of making health a reality for all the people of India. The primary health care principle encompasses the goals of equity and social justice in health. These goals are to be attained primarily through the mobilization of all available resources in the community. This mobilization and harnessing of resources must be done through effective community “participation” and “involvement”, and this participation and involvement must be encouraged and promoted through “education” and the “empowerment” of people.

Recognizing health as “a fundamental right of everyone”, regardless of social class, is an important requisite in the successful development and implementation of the PHC principle that calls for “social control” of “health knowledge” and “health technology”.

Health for all through the PHC approach requires “unconditional access” to health care by all people everywhere. The hard-to-reach or unreached must be reached and served, with their “human dignity” duly recognized.

Distinguished participants,

The PHC principle has served people of the world very well in their quest for “health for all”. This contribution of PHC was in evidence even before the Alma Ata Declaration on PHC 32 years ago, when it was globally endorsed as the key to the “social goal of Health For All” at the International Conference on PHC in 1978. Within the context of “the social goal of Health for All”, it is universally accepted that PHC has significantly contributed to health improvement of all people around the world. This contribution has been mainly through “overall social and economic development” in countries, in addition to direct contribution from health programmes.

Developing countries have had more health benefits from the implementation of the PHC principle. On average, people today live longer and enjoy a healthier life than they did 30 years ago. However, much remains to be done in our journey towards the social goal of health for all. There is still a big number of poor, underserved, underprivileged and vulnerable people who are yet to be adequately taken care of. These people – the poor,

underprivileged, underserved and the vulnerable - who are yet to adequately benefit from health systems that are based on PHC principle.

In addition to further pursuance of the “unfinished agenda” of HFA, there is a multitude of emerging challenges that currently threaten human health security worldwide. These are, climate change, pandemics of new and emerging pathogens, aged populations, lifestyle changes, rapid and unplanned urbanization and adverse effects of globalization. The people in developing countries are disproportionately affected by these challenges and threats. And they are, especially, the poor, underprivileged, underserved and vulnerable.

We understand that health situations worldwide evolve over time according to the environmental and ecological changes. These changes are not only in physical but also in social, economic and political terms. Health systems, within which PHC is playing its role, have to be reoriented to effectively face such changes. Health systems strengthening must be pursued on the basis of the PHC principle of “good health for all people” of a country and the world. Reorientation of the PHC approach is to ensure “continued relevance” of health systems to health needs especially of the poor, underprivileged and vulnerable. With the emerging health challenges today, PHC needs innovations in its approach in order to continue to be relevant and effective. It is necessary in this context to encourage more multidisciplinary and multisectoral involvement.

Achievements in health, in terms of both physical, mental and social wellbeing, are part of a “social goal” that encompasses all elements of the “quality of life”. This goal

cannot be attained only through the health sector or by health programmes alone. The goal calls for incorporating “health in all development policies”.

Ladies and gentlemen,

In 2008, the Regional Conference on Revitalizing PHC was held to review the past and the present of PHC. The Conference looked into the future of PHC in terms of its revitalization and the continued relevance to the health and other social needs in the community. It was agreed at the Conference that a “development-based rather than service-based approach” should be the basis for revitalizing PHC. The ultimate aim of PHC should be achieving self-reliance in health care by all people, individually and collectively, with emphasis on the poor and the underserved. To fulfill this aim, every individual in the community must be empowered through appropriate educational processes. Health knowledge must be adequately “demystified” to be understood by all people, according to their needs. Health technology must be “appropriately developed” for use by all people at different levels. Local or indigenous technology must be developed for more effective use by people in the community.

We have to pay more attention to and invest more resources in the strengthening and further development of a community-based health workforce: the workforce that consists principally of community-based health workers and community-based health volunteers. This is so that these people can function as effective “change agents” in the community and among the people. These “change agents” are to catalyse and facilitate the changes in people’s attitudes, behaviours and practices in health. This catalysis is to be pursued through “educational and empowerment processes”. This is in addition to the

services to be provided by the community-based health workforce in responding to the health-care needs at the grassroots level.

The community-based health workforce, if properly developed and strengthened, will be able to contribute more and better and would be able to shoulder “additional responsibility” over providing health care in an efficient and effective manner. Development of the community-based health-care process can relieve the burden on health facilities at the secondary and tertiary levels.

Very importantly, through their work in health promotion and disease prevention the community-based health workforce is able, to a large extent, to help keep the population healthy for as much as and as long as possible. The community-based health workforce can help reduce the use of expensive medicines and medical equipment. Such development, therefore, can help lessen “the investment” in secondary and tertiary levels of care. It can, also, contribute significantly towards stemming any skyrocketing increase in health-care costs.

To be effective, the development of community-based health care on the basis of the PHC principle must go hand in hand with policy change at the national level. National health policies must ensure, among other things, a well balanced allocation of health resources between “preventive” and “curative” care. The policies must ensure adequate referral and other institutional support to community-based health-care systems.

Ladies and gentlemen,

Countries in the South-East Asia Region can be justifiably proud that the seeds of the “PHC movement” had been sown long before the Alma Ata Declaration. Several successful piloting of PHC initiatives in the Region had been achieved in the past. These include:

- “Basic minimum needs” in Thailand;
- “Posayandu scheme” in Indonesia;
- “Ayador Health Development Initiative” in Myanmar; and
- “Mongar Health Development Project” in Bhutan.

Now, efforts are being made at further development of PHC innovations, such as:

- “Strategic Road Map” in Thailand;
- “Network of Community Health Clinics” in Bangladesh;
- “Integrated Health Posts” in Indonesia; and
- “Integrated Development of Community Health Services or SISCA” in Timor-Leste.

In India, community participation in health is further strengthened through the use of Accredited Social Health Activists (ASHAs) under the National Rural Health Mission. This is another example worthy of mention. In Sri Lanka, PHC is being reoriented to ensure effective community-based services for NCDs.

The Regional Consultation on Innovations in PHC was held in August 2010 in Chiang Mai, Thailand, to share experiences among countries. The consultation chalked out a roadmap for regional endeavours for the future development of such innovations. Through collaborations among several institutions in the Region, the South-East Asia PHC Innovations Network (SEAPIN) was established. This Network will serve as a mechanism for the exchange of ideas, experiences and learning among countries. The mechanism will contribute significantly to the PHC revitalization process in the WHO South-East Asia Region. I am pleased to note that the VHAI is also a founder member of this Network.

Ladies and gentlemen,

Community “education” and “empowerment” is the essence of improving the health of all people. Organizations such as VHAI and others represented in the meeting today are close to the people in the community. They are in the best position to promote and support such “education” and “empowerment” that can effectively contribute to the “reality of health for all for the people of India”. This is the crucial role played by the voluntary sector in supporting the Government’s initiatives such as the National Rural Health Mission.

I am also happy to note that VHAI and its partner agencies are regularly consulted by the Government of India (GoI) for health programme-related issues. I highly commend the GoI for involving civil society organizations in its social sector programmes, including the NRHM initiative. Public-private partnerships of this nature can vastly contribute to the improved efficiency and effectiveness of national health development programmes.

In the end, ladies and gentlemen, I would like to thank the VHAI for inviting me to the 36th Annual General Body Meeting.

I wish your deliberations all success.

Thank you.